FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 SOUTH PEARL STREET (Number) BELVIDERE (City) 61008 (Zip Code)

County: BOONE

Telephone Number: (815) 544-0358 **Fax #** (815) 544-5006

IDPA ID Number: 36-3954529

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,901	3,990	5,513	19,404	8
9	SNF/PED					9
10	ICF	10,598	4,272	1,575	16,445	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,499	8,262	7,088	35,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.67%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 116 and days of care provided 3,424

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	173,983	12,264	10,629	196,876		196,876	3,521	200,397			1
2	Food Purchase		129,737		129,737		129,737	(638)	129,099			2
3	Housekeeping	224,007	30,691		254,698		254,698	(223)	254,475			3
4	Laundry	45,028	13,850	4,206	63,084		63,084	(734)	62,350			4
5	Heat and Other Utilities			105,859	105,859		105,859		105,859			5
6	Maintenance	31,409	22,192	27,586	81,187		81,187	(215)	80,972			6
7	Other (specify):*			4,809	4,809		4,809		4,809			7
8	**TOTAL General Services**	474,427	208,734	153,089	836,250		836,250	1,711	837,961			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,475,918	91,714	89,346	1,656,978		1,656,978	(39,287)	1,617,691			10
10a	Therapy			889	889		889		889			10a
11	Activities	132,124	6,748	3,582	142,454		142,454	(3,666)	138,788			11
12	Social Services	49,659		716	50,375		50,375		50,375			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,657,701	98,462	102,333	1,858,496		1,858,496	(42,953)	1,815,543			16
	C. General Administration											
17	Administrative	95,855		424,770	520,625		520,625	(425,748)	94,877			17
18	Directors Fees											18
19	Professional Services			235,409	235,409		235,409	(154,241)	81,168			19
20	Dues, Fees, Subscriptions & Promotions			58,722	58,722		58,722	(44,367)	14,355			20
21	Clerical & General Office Expenses	83,580	28,757	33,333	145,670		145,670	112,617	258,287			21
22	Employee Benefits & Payroll Taxes			460,721	460,721		460,721		460,721			22
23	Inservice Training & Education			5,923	5,923		5,923		5,923			23
24	Travel and Seminar							6,339	6,339			24
25	Other Admin. Staff Transportation			3,568	3,568		3,568		3,568			25
26	Insurance-Prop.Liab.Malpractice			117,505	117,505		117,505	14,286	131,791			26
27	Other (specify):*			14,575	14,575		14,575	(14,575)				27
28	**TOTAL General Administration**	179,435	28,757	1,354,526	1,562,718		1,562,718	(505,689)	1,057,029			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,311,563	335,953	1,609,948	4,257,464		4,257,464	(546,931)	3,710,533			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,641	
	REPAIRS & MAINTENANCE		988	
			0	10,629
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,206	
			0	4,206
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		50,696	
	ELECTRICITY		34,717	
	WATER		17,568	
	CABLE TV - LOBBY		2,878	
			0	105,859
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,729	
	PAINTING & DECORATING		924	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		14,216	
	ELEVATOR MAINTENANCE & REPAIR		5,375	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		630	
	FIRE SERVICE		1,712	
			0	
			0	
			0	27,586
7	**OTHER**			
	SCAVENGER		4,588	
	SECURITY SERVICE		221	4,809
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,800	7,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	13,200	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,440	
	UTILIZATION REVIEW FEES	XVIII B 48-2	7,800	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	66,906	
			0	
			0	89,346
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		153	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		405	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	331	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	889
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,582	
			0	3,582
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		171	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	545	
			0	716
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	424,770	424,770
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,298	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	215,111	
			0	235,409
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	35,825	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,950	
	EMPLOYEE WANT ADS	XIX F	4,012	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	6,827	
	LICENSES & PERMITS	XIX F	758	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,018	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,832	58,722
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,179	
	EQUIPMENT REPAIR & MAINTENANCE		2,607	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,572	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,328	
	MESSENGER SERVICE		647	
			0	33,333

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	175,220	
	UNEMPLOYMENT COMPENSATION	XIX D	41,072	
	WORKERS COMPENSATION INSURANCI	XIX D	58,342	
	HOSPITALIZATION INSURANCE	XIX D	168,603	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,809	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,446	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,229	
	CHICAGO HEAD TAX	XIX D	0	460,721
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,923	5,923
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,568	3,568
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		117,505	117,505
27	**OTHER**			
	BAD DEBTS	VI 24	14,575	
				14,575

GRAND TOTAL COLUMN 3 OTHER 1,609,948

NORTHWOODS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	129,737	PATIENT MEALS	107547
LESS SALES TAX	(638)	ADD EMPLOYEE MEALS	0
NET FOOD	129,099	TOTAL MEALS/YEAR	107547
TOTAL PATIENT CENSUS	35,849	NET FOOD	129099
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	107547
TOTAL PATIENT MEALS	107547	COST PER MEAL	1.2
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			47,274	47,274		47,274	75,995	123,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,217	2,217		2,217	117,772	119,989			32
33	Real Estate Taxes			72,373	72,373		72,373		72,373			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(414,771)	23,229			34
35	Rent-Equipment & Vehicles			22,812	22,812		22,812	5,848	28,660			35
36	Other (specify):* STORAGE			1,800	1,800		1,800		1,800			36
37	**TOTAL Ownership**			584,476	584,476		584,476	(215,156)	369,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,424	170,913	313,337		313,337		313,337			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		142,424	234,423	376,847		376,847		376,847			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,311,563	478,377	2,428,847	5,218,787		5,218,787	(762,087)	4,456,700			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(661)	30		9
10	Interest and Other Investment Income	(2,217)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(638)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,572)	21		18
19	Entertainment	(35,825)	20		19
20	Contributions	(4,518)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(8,463)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,575)	27		24
25	Fund Raising, Advertising and Promotional	(4,950)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	202			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,217)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(683,870)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (683,870)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (762,087)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 541	6	1
2	VACATION ACCRUAL	3,521	1	2
3	VACATION ACCRUAL	(223)	3	3
4	VACATION ACCRUAL	(734)	4	4
5	VACATION ACCRUAL	(756)	6	5
6	VACATION ACCRUAL	1,012	10	6
7	VACATION ACCRUAL	(3,666)	11	7
8	VACATION ACCRUAL	(1,895)	17	8
9	VACATION ACCRUAL	2,402	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	202		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	3,521	0	0	0	0	0	0	0	0	0	0	3,521	1
2	Food Purchase	(638)	0	0	0	0	0	0	0	0	0	0	(638)	2
3	Housekeeping	(223)	0	0	0	0	0	0	0	0	0	0	(223)	3
4	Laundry	(734)	0	0	0	0	0	0	0	0	0	0	(734)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(215)	0	0	0	0	0	0	0	0	0	0	(215)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,711	0	0	0	0	0	0	0	0	0	0	1,711	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	1,012	0	0	(40,299)	0	0	0	0	0	0	0	(39,287)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,666)	0	0	0	0	0	0	0	0	0	0	(3,666)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,654)	0	0	(40,299)	0	0	0	0	0	0	0	(42,953)	16
	C. General Administration													
17	Administrative	(1,895)	0	(317,660)	0	0	(106,193)	0	0	0	0	0	(425,748)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,463)	8,004	(47,470)	863	(107,175)	0	0	0	0	0	0	(154,241)	19
20	Fees, Subscriptions & Promotions	(45,293)	0	514	172	240	0	0	0	0	0	0	(44,367)	20
21	Clerical & General Office Expenses	(4,170)	0	18,040	1,280	97,467	0	0	0	0	0	0	112,617	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,790	2,977	1,572	0	0	0	0	0	0	6,339	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,846	1,015	1,212	1,213	0	0	0	0	0	0	14,286	26
27	Other (specify):*	(14,575)	0	0	0	0	0	0	0	0	0	0	(14,575)	27
28	TOTAL General Administration	(74,396)	18,850	(343,771)	6,504	(6,683)	(106,193)	0	0	0	0	0	(505,689)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,339)	18,850	(343,771)	(33,795)	(6,683)	(106,193)	0	0	0	0	0	(546,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(661)	76,656	0	0	0	0	0	0	0	0	0	75,995	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,217)	119,989	0	0	0	0	0	0	0	0	0	117,772	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(438,000)	0	720	22,509	0	0	0	0	0	0	(414,771)	34
35	Rent-Equipment & Vehicles	0	0	1,859	2,639	1,350	0	0	0	0	0	0	5,848	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,878)	(241,355)	1,859	3,359	23,859	0	0	0	0	0	0	(215,156)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,217)	(222,505)	(341,912)	(30,436)	17,176	(106,193)	0	0	0	0	0	(762,087)	45

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		NORTHWOODS HEALTHCARE CENTRE		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 438,000	NORTHWOODS HEALTHCARE CENTRE		$	$ (438,000)	1
2	V	19	ACCOUNTING FEES		" "		7,800	7,800	2
3	V	26	MORTGAGE INSURANCE		" "		10,846	10,846	3
4	V	30	DEPRECIATION - BLDG/IMP		" "		76,321	76,321	4
5	V	30	DEPRECIATION - EQPT/FURN		" "		335	335	5
6	V	32	AMORTIZATION - MTG COST		" "		806	806	6
7	V	32	INTEREST - MORTGAGE		" "		108,365	108,365	7
8	V	32	INTEREST - OTHER		" "		10,818	10,818	8
9	V	19	DATA PROCESSING		" "		204	204	9
10	V	21	OFFICE EXPENSES		" "				10
11	V								11
12	V								12
13	V								13
14	Total			$ 438,000			$ 215,495	$ * (222,505)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 55,585	WITTINGHAM MANAGEMENT ASSOCIATES		$ 8,115	$ (47,470)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		514	514	16
17	V	21	CLERICAL		" "		18,040	18,040	17
18	V	24	TRAVEL		" "		1,790	1,790	18
19	V	26	INSURANCE		" "		1,015	1,015	19
20	V	35	RENT - EQPT & VEH		" "		1,859	1,859	20
21	V	17	ADMINISTRATIVE	318,577	" "		917	(317,660)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 374,162			$ 32,250	$ * (341,912)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 66,906	CARLYLE NURSING ASSOCIATES, LLC		$ 26,607	$ (40,299)	15
16	V	19	PROFESSIONAL FEES		" "		863	863	16
17	V	20	DUES & SUBSCRIPTIONS		" "		172	172	17
18	V	21	CLERICAL		" "		1,280	1,280	18
19	V	24	TRAVEL		" "		2,977	2,977	19
20	V	26	INSURANCE		" "		1,212	1,212	20
21	V	30	DEPRECIATION		" "				21
22	V	34	RENT		" "		720	720	22
23	V	35	RENT - EQPT & VEH		" "		2,639	2,639	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,906			$ 36,470	$ * (30,436)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 110,069	THE KENSINGTON GROUP, LLC		$ 2,894	$ (107,175)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		240	240	16
17	V	21	CLERICAL		" "		97,467	97,467	17
18	V	24	TRAVEL		" "		1,572	1,572	18
19	V	26	INSURANCE		" "		1,213	1,213	19
20	V	30	DEPRECIATION		" "				20
21	V	34	RENT		" "		22,509	22,509	21
22	V	35	RENT - EQPT & VEH		" "		1,350	1,350	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 110,069			$ 127,245	$ * 17,176	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 106,193	CHESTERFIELD, LLC		$	$ (106,193)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 106,193			$ 0	$ * (106,193)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583 - 0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	328,617	6	$ 74,383	$	35,849	$ 8,115	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	328,617	6	4,713		35,849	514	2
3	21	CLERICAL	PATIENT DAYS	328,617	6	165,350	139,276	35,849	18,040	3
4	24	TRAVEL	PATIENT DAYS	328,617	6	16,404		35,849	1,790	4
5	26	INSURANCE	PATIENT DAYS	328,617	6	9,305		35,849	1,015	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	328,617	6	17,037		35,849	1,859	6
7	17	ADMINISTRATIVE	PATIENT DAYS	328,617	6	8,406	8,406	35,849	917	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 295,598	$ 147,682		$ 32,250	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 26,607	$ 26,607	1	$ 26,607	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	11,646		35,849	863	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	2,323		35,849	172	3
4	21	CLERICAL	PATIENT DAYS	483,650	9	17,276		35,849	1,280	4
5	24	TRAVEL	PATIENT DAYS	483,650	9	40,167		35,849	2,977	5
6	26	INSURANCE	PATIENT DAYS	483,650	9	16,351		35,849	1,212	6
7	30	DEPRECIATION	PATIENT DAYS	483,650	9			35,849		7
8	34	RENT	PATIENT DAYS	483,650	9	9,715		35,849	720	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	35,603		35,849	2,639	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 159,688	$ 26,607		$ 36,470	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	$ 39,055	$	35,849	$ 2,894	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234		35,849	240	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	1,150,879	35,849	97,467	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213		35,849	1,572	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374		35,849	1,213	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9			35,849		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769		35,849	22,509	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	18,215		35,849	1,350	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,717,200	$ 1,150,879		$ 127,245	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$34,916.44	12/03	2,052,500	2,012,132	12/38	5.3500	108,365	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		28,226	26,578			806	3
4												4
5												5
	Working Capital											
6	LETTER OF CREDIT FEE		X								2,217	6
7	RELATED PARTIES	X		WORKING CAPITAL	DEMAND	VARIES	377,804	233,654	DEMAND	4.7500	10,818	7
8												8
9	TOTAL Facility Related				$34,916.44		$ 2,458,530	$ 2,272,364			$ 122,206	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,458,530	$ 2,272,364			$ 122,206	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 71,532	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 71,557	2
3. Under or (over) accrual (line 2 minus line 1).	$ 25	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 72,348	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 72,373	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	69,802	8
2001	67,798	9
2002	70,821	10
2003	70,748	11
2004	71,557	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-01-151-003	NURSING HOME	$ 71,557.16	$ 71,557.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,557.16	$ 71,557.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1981	$ 50,050	1
2	754 BASIS ADJ.		1982	4,835	2
3	TOTALS			$ 54,885	3

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1981		$ 995,068	$	30	$ 33,169	$ 33,169	$ 829,225	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		47,990	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS			1981	4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS			1982	73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS			1983	6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS			1984	11,372		20			11,372	13
14	PAVING			1986	13,000		15			13,000	14
15	SHOWER			1986	4,151	309	25	166	(143)	3,237	15
16	ROOF			1988	38,383	1,219	31.5	1,219		21,383	16
17	DECORATING			1989	1,921	61	31.5	61		994	17
18	VARIOUS IMPROVEMENTS			1990	10,047	319	31.5	319		5,104	18
19	VARIOUS IMPROVEMENTS			1991	2,683	85	31.5	85		1,358	19
20	VARIOUS IMPROVEMENTS			1992	38,565	1,224	31.5	1,224		16,286	20
21	CARPET			1993	6,854	217	31.5	217		2,755	21
22	DRIVEWAY			1993	1,655	42	39	42		508	22
23	SPRINKMAN SONS			1993	1,525	39	39	39		439	23
24	VARIOUS IMPROVEMENTS			1994	3,137	209	15	209		2,403	24
25	VARIOUS IMPROVEMENTS			1994	170,951	6,216	27.5	6,216		64,039	25
26	DOORS			1995	5,029	129	39	129		1,400	26
27	LANDSCAPING			1996	51,185	1,861	27.5	1,861		17,347	27
28	ROOF REPAIR			1996	20,000	727	27.5	727		6,650	28
29	DRIVEWAY REPAIR			1996	4,775	174	27.5	174		1,560	29
30	CONCRETE RETAINING WALL FOR RAMP			1997	1,500	55	27.5	55		458	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES			1997	46,256	1,682	27.5	1,682		13,901	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION			1997	30,000	1,091	27.5	1,091		8,910	32
33	450000-GRAIN UNITS - WATER SOFTENER/COUNTER TOPS			1997	11,248	409	27.5	409		3,332	33
34	THREE WAY OVER BED RESIDENT LIGHTING			1998	12,600	458	27.5	458		3,327	34
35	GARBAGE DISPOSAL - KITCHEN REMODELING			1998	1,189	43	27.5	43		321	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WINDOWS AND AUTO DOOR SYSTEM	1998	$ 25,000	$ 909	27.5	$ 909	$	$ 6,628	37
38	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	68,941	2,507	27.5	2,507		19,363	38
39	TILES	1998	3,164	115	27.5	115		877	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		1,275	40
41	COUNTER TOPS	1998	17,763	646	27.5	646		4,813	41
42	ELECTRICAL WIRING	1998	3,675	134	27.5	134		1,010	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		33,847	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		7,348	44
45	REMODELING - HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		24,998	45
46	TILES	1999	3,924	143	27.5	143		876	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		588	47
48	REMODELING - ARCHITECTURE	2000	4,000	145	27.5	145		864	48
49	BLACKTOP STRIPPING & SEALING	2000	4,050	270	15	270		1,485	49
50	AIRTHERM HEATERS	2000	34,363	1,249	27.5	1,249		6,610	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		761	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		353	52
53	FIRE ALARM PANEL	2001	2,388	87	27.5	87		402	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		1,080	54
55	CARPETING - 1ST FLR CRDR, NSG OFFICE, ENTRYWAY	2002	12,079	1,392	5	2,416	1,024	11,113	55
56	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	1,694	27.5	1,694		5,576	56
57	F & I.A.O SMITH WATER HEATER	2002	4,600	167	27.5	167		550	57
58	FURNISH & INSTALL BOILER	2003	25,591	930	27.5	930		2,752	58
59	COMPLETE CANTILEVER RE-CONSTRUCTION	2004	14,133	514	27.5	514		1,007	59
60	INSTALL FLOOR DRAIN AND VENT	2004	834	30	27.5	30		51	60
61	REPLACE OBSOLETE ELEVATOR VALVES AND PARTS	2004	22,539	820	27.5	820		1,401	61
62	REPLACE SEWER LINE BETWEEN GREASE TRAP & MACH	2004	1,990	72	27.5	72		99	62
63	INSTALL NEW EXHAUST FAN & DUCT WORK IN LNDRY R	2005	1,185	31	27.5	31		31	63
64	SMOKE BARRIERS INSTALLED IN 1ST & 2ND FLR CORRDI	2005	14,945	204	27.5	204		204	64
65	REPLACED AND ADJUSTED DOORS	2005	6,902	94	27.5	94		94	65
66	INSTALL HOT WATER CONTROL VALVE	2005	4,142	6	27.5	6		6	66
67									67
68			ADJ. TO SL	34,050			(34,050)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,271,154	$ 76,321		$ 76,321	$	$ 1,297,077	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 567,709	$ 38,498	$ 44,419	$ 5,921	3-15 YRS	$ 279,006	71
72	Current Year Purchases	43,883	8,776	2,194	(6,582)	3-15 YRS	2,194	72
73	Fully Depreciated Assets	15,411					15,411	73
74	RELATED PARTIES		335	335				74
75	TOTALS	$ 627,003	$ 47,609	$ 46,948	$ (661)		$ 296,611	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,953,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,269	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (661)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,593,688	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	SPEED BUMPERS	$ 31,206	92
93			93
94			94
95		$ 31,206	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 9,060 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM -VAN	$ 295.13	$ 3,542	17
18	ADMINISTRATIVE	2004 FORD CLUB WGN	850.00	10,210	18
19					19
20					20
21	TOTAL		$ #######	$ 13,752	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 83,120	$		$ 83,120	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,348			7,348	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,445			80,445	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				118,420		118,420	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					24,004		24,004	13
14	TOTAL			$		$ 170,913	$ 142,424		$ 313,337	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 326,969	$ 645,618	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,334)	870,909	870,909	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,673	91,157	6
7	Other Prepaid Expenses	64,233	64,233	7
8	Accounts Receivable (owners or related parties)	5,481	5,481	8
9	Other(specify): ESCROW DEPOSITS		576,565	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,300,265	$ 2,253,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	705,443	1,013,847	11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,164,119	15
16	Equipment, at Historical Cost	627,002	663,958	16
17	Accumulated Depreciation (book methods)	(555,786)	(1,938,184)	17
18	Deferred Charges	4,776	31,354	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR. IN PROGRESS		31,206	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 781,435	$ 2,011,418	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,081,700	$ 4,265,381	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 402,362	$ 207,520	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	174,088	174,088	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,734	87,734	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,213	13,213	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,348	32
33	Accrued Interest Payable		8,971	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES			36
37	DUE TO DPA	13,532	13,532	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 690,929	$ 577,406	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,012,132	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,012,132	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 690,929	$ 2,589,538	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,390,771	$ 1,675,843	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,081,700	$ 4,265,381	48

*(See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,991,601	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,991,599	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,172	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,750,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) REPLACEMENT TAX		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,600,828)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,390,771	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,335,100	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,335,100	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	146	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 146	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,713	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,713	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,367,959	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	836,250	31
32	Health Care	1,858,496	32
33	General Administration	1,562,718	33
	B. Capital Expense		
34	Ownership	584,476	34
	C. Ancillary Expense		
35	Special Cost Centers	313,337	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,218,787	40
41	**Income before Income Taxes (line 30 minus line 40)****	149,172	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 149,172	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,086	2,391	$ 80,850	$ 33.81	1
2	Assistant Director of Nursing	1,932	2,141	52,735	24.63	2
3	Registered Nurses	13,361	14,744	372,057	25.23	3
4	Licensed Practical Nurses	13,125	14,400	287,470	19.96	4
5	CNAs & Orderlies	54,730	57,966	624,134	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	925	1,212	18,146	14.97	9
10	Activity Assistants	13,879	14,592	113,978	7.81	10
11	Social Service Workers	3,433	3,759	49,659	13.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,387	5,932	73,312	12.36	14
15	Cook Helpers/Assistants	11,289	11,994	100,671	8.39	15
16	Dishwashers					16
17	Maintenance Workers	2,269	2,328	31,409	13.49	17
18	Housekeepers	21,978	23,624	224,007	9.48	18
19	Laundry	4,836	5,272	45,028	8.54	19
20	Administrator	1,917	2,086	95,855	45.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,184	6,100	83,580	13.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,581	3,968	58,672	14.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,912	172,509	$ 2,311,563 *	$ 13.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	213	$ 9,641	1-3	35
36	Medical Director	72	7,800	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	534	66,906	10-3	38
39	Pharmacist Consultant	192	1,440	10-3	39
40	Physical Therapy Consultant	6	331	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	56	3,582	11-3	44
45	Social Service Consultant	9	545	12-3	45
46	Other(specify)				46
47	PSYCHO SOCIAL CONSLT.	96		10-3	47
48	U.R. CONSULTANT	72		10-3	48
49	TOTAL (lines 35 - 48)	1,250	$ 90,245		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN MEAD	ADMIN		$ 95,855
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,855

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC. MNGMT FEE	$ 318,577
YORK MANAGEMENT ASSOC. - MNGMNT FEE	106,193
TOTAL (agree to Schedule V, line 17, col. 3)	$ 424,770
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		235,409
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 235,409

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 58,342
Unemployment Compensation Insurance		41,072
FICA Taxes		175,220
Employee Health Insurance		168,603
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		8,809
EMPLOYEE PHYSICAL EXAMS		1,446
PENSION/PROFIT SHARING PLANS		7,229
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 460,721

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,012
Health Care Worker Background Check	1,832
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	40,775
TRUST/FRANCHISE/CONTRIB/ETC	4,518
LICENSES & PERMITS	758
DUES & SUBSCRIPTIONS	6,827
MGMT CO ALLOCATION	926
TRUST/FRANCHISE/CONTRIB/ETC	(4,518)
Less: Public Relations Expense	(35,825)
Non-allowable advertising	(4,950)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,355

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
MANAGEMENT COMPANY ALLOC.	6,339
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,339

**See instructions.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	06/2003	$ 1,623	3	$	$ 271	$ 541	$ 541	$ 270	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,623		$	$ 271	$ 541	$ 541	$ 270	$	$	$	$

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL. COUNCIL ON LONG TERM CARE-$6624**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,748** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **63,510**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees